Protection for Persons in Care

ANNUAL REPORT
2004 - 2005

Alberta
SENIORS AND
COMMUNITY SUPPORTS

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Protection for Persons in Care Act

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Note: Formerly, Protection for Persons in Care prepared quarterly reports and an annual report. In 2004/05, Protection for Persons in Care discontinued its quarterly reports and began preparing monthly reports, which are posted on the ministry website.

The objective of this report is to describe complaints received and investigated based on an analysis of the data generated by the Protection for Persons in Care information and reporting system (PPC Production).

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General Information

Protection for Persons in Care responds to complaints of abuse by conducting investigations and making recommendations to prevent similar incidents of abuse in the future, increase safeguards, and improve the safety and well-being of adults receiving publicly funded care services.

Protection for Persons in Care is guided by the following principles:

- Every adult Albertan receiving care services from an agency as defined in the *Protection for Persons in Care Act* should be safeguarded from abuse.
- Protection for Persons in Care actively promotes the best interest, safety and well-being of clients receiving care services.
- Protection for Persons in Care is committed to responding to all complaints under its jurisdiction in a timely manner, while ensuring investigations are conducted thoroughly, objectively and professionally.
- All recommendations made to agencies should be aimed at strengthening the agency's capacity to prevent abuse from occurring.
- The concepts of equity and fairness apply to everyone involved in an investigation. All individuals affected by an investigation should have the opportunity to respond to the complaint.

The Protection for Persons in Care office has responsibilities in four main areas:

- Receiving complaints of abuse.
- Investigating complaints of abuse.
- Making recommendations to facilities to prevent abuse from occurring in the future.
- Providing education and promoting awareness of abuse, prevention and the requirements of the *Protection for Persons in Care Act*.

Governing Legislation

The *Protection for Persons in Care Act*, which came into effect on January 5, 1998, is the legislation that enables Seniors and Community Supports to respond to complaints of abuse. The *Protection for Persons in Care Act* applies to adults receiving services from agencies such as seniors' lodges, hospitals, nursing homes, women's shelters, homeless shelters, group homes, residential alcohol and drug abuse treatment centres and other places that provide special care including some agencies that receive funding through Persons with Developmental Disabilities community boards.

The *Protection for Persons in Care Act* defines abuse as:

- intentionally causing bodily harm,
- intentionally causing emotional harm,
- intentionally administering or prescribing medication for an inappropriate purpose,
- subjecting to non-consensual sexual contact, activity or behaviour,
- intentionally misappropriating or improperly or illegally converting money or other valuable possessions, or

- intentionally failing to provide adequate nutrition, adequate medical attention or other necessity of life without a valid consent.

It is mandatory for any person who has reasonable and probable grounds to believe that abuse has occurred, to report such abuse to Protection for Persons in Care, the police or a professional association.

Upon receiving a report of abuse, the department must appoint a person to investigate the complaint. If the department or the investigator is of the opinion that the nature of the complaint could constitute an offence under the *Criminal Code (Canada)*, the complaint must be referred to the police as soon as possible. If the complaint involves a health professional, the complaint may be referred to a professional association.

After completing an investigation, the investigator must submit a final report to the Ministry. In the report, the investigator may recommend any of the following:

- that the funding of the agency involved in the complaint be reviewed or altered,
- that the agency involved in the complaint take disciplinary action against an employee or service provider,
- that the complaint be dismissed because
    i. the complaint was made maliciously,
    ii. the complaint was made without reasonable and probable grounds for the belief, or
    iii. the complaint is unfounded or the evidence is insufficient;
- any other recommendation that the investigator considers appropriate in the circumstances.

After reviewing the investigator's final report, the Ministry may:

- approve the recommendations of the investigator in whole or in part,
- reject the recommendations of the investigator,
- order that the investigator undertake a further investigation, or
- take any other action that is considered appropriate in the circumstances.

The decision is final and binding.

The Ministry must provide a copy of the decision to the complainant and to the agency involved in the complaint. In practice, copies of the decision are also provided to the alleged abuser(s) and to the governing entity responsible for the services that have been provided. This expanded distribution helps in providing a greater degree of administrative fairness and in ensuring a higher level of overall accountability for the delivery system.

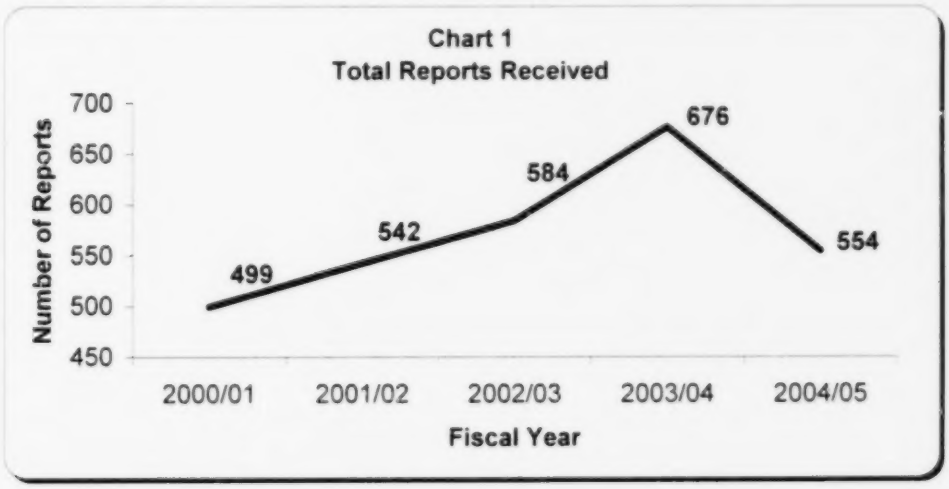
Summary of Reports of Abuse

In 2004/05, Protection for Persons in Care received 554 reports of abuse. Of the 554 reports, four were referred to a professional association for investigation and remain open.

There was an 18 per cent reduction in the total number of reports received in 2004/05 compared to 2003/04 in which 676 reports were received. The reduction in overall reports of abuse is attributed to substantially fewer reports received involving clients served by Persons with Developmental Disabilities community boards and fewer reports received involving residents of seniors' lodges.

During the 12-month period, Protection for Persons in Care received an average of 46 complaints per month. The month of March 2005 had the highest number of reports (59) and the months of May and September 2004 had the lowest (40 per month).

Since 2000/01, the Protection for Persons in Care office has dealt with 2,855 reports of abuse, an average of 571 per year. Chart 1 shows a steady growth in reports received by Protection for Persons in Care over a five-year period, peaking in 2003/04 with 676 reports.



Reports by Ministry and Regional Authority

Agencies and facilities that fall under the responsibility of Health and Wellness accounted for 73 per cent of all reports received in 2004/05. Twenty-six per cent of reports related to agencies that are under Seniors and Community Supports. Two reports (less than one per cent of all reports) related to facilities under the responsibility of Children's Services.

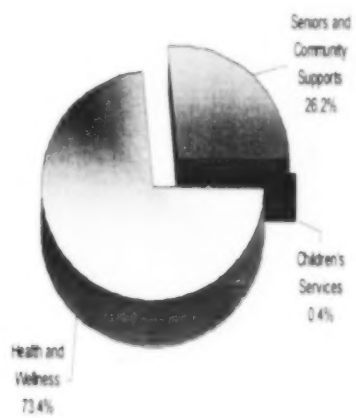
The most significant change from the previous fiscal year is that fewer reports were received involving agencies under the Persons with Developmental Disabilities community boards. In 2004/05, a total of 95 reports were received involving Persons with Developmental Disabilities settings, whereas in 2003/04, 182 reports were received. Similarly, there were fewer reports related to seniors' lodges. In 2004/05, 48 reports were received involving residents of seniors' lodges compared to 73 reports in 2003/04.

Table 1
Total Reports by Ministry and Regional Authority

Health & Wellness	Regional Health Authority	Reports
	RHA #1Chinook	22
	RHA #2 Palliser	19
	RHA #3 Calgary	100
	RHA #4 David Thompson	35
	RHA #5 East Central	26
	RHA #6 Capital	147
	RHA #7 Aspen	12
	RHA #8 Peace Country	44
	RHA #9 Northern Lights	0
	Alberta Alcohol and Drug Abuse Commission	2
	Ministry Total	**407**
Seniors and Community Supports	**Persons with Developmental Disabilities Community Boards**	**Reports**
	Northeast Community Board	1
	Northwest Community Board	1
	Edmonton Community Board	17
	Central Community Board	65
	Calgary Community Board	4
	South Community Board	7
		95
	Seniors' Lodges	48
	Homeless Shelters	2
	Ministry Total	**145**
Children's Services		**Reports**
	Women's Shelters	2
	Ministry Total	**2**

* Note: Persons with Developmental Disabilities community boards were formerly under the jurisdiction of the ministry of Community Development from April 1 to November 24, 2004.

Chart 2
Total Reports by Ministry and Regional Authority



Note: Regional Health Authorities are authorities governed by the *Regional Health Authorities Act*. PDD Community Boards are authorities governed by the *Persons with Developmental Disabilities Community Governance Act*.

Complaints by Type of Abuse

The 554 reports received involved 779 complaints of abuse. Complaints by type of abuse are greater than total reports because one report may involve multiple allegations and/or more than one type of abuse.

Emotional harm continues to be the most common type of abuse reported (52% of all complaints), followed by bodily harm (20%), failure to provide the necessities of life (19%), sexual contact (5%), financial (3%) and inappropriate medication administration (1%). This is consistent with the previous year.

The actual number of complaints of "failure to provide the necessities of life without a valid consent" increased from 126 complaints in 2003/04 to 148 complaints in 2004/05. There was a significant reduction in the number of complaints involving "misappropriating money or possessions" from 60 complaints in 2003/04 to 20 complaints in 2004/05.

Table 2

Types of Abuse Complaints

Types of Abuse	2004/05		2003/04	
	Actual	Percentage	Actual	Percentage
Emotional harm	403	52%	427	51%
Bodily harm	157	20%	161	19%
Failing to provide the necessities of life without a valid consent	148	19%	126	15%
Sexual contact, activity or behaviour	36	5%	50	6%
Misappropriating money or possessions	20	3%	60	7%
Inappropriate medication administration	15	1%	13	2%
	779	**100%**	**837**	**100%**

Distribution of Complaints by Type of Abuse

Table 3 shows complaints by type of abuse across the various types of facilities or settings in each ministry. With the exception of homeless shelters, complaints of emotional harm are prevalent across all facility types.

Table 3

Distribution of Complaints by Type of Abuse

		Emotional Harm	Bodily Harm	Failing to Provide the Necessities of Life	Sexual	Financial	Inappropriate Medication
HEALTH AND WELLNESS	**Nursing Homes and Auxiliary Hospitals**	49%	19%	22%	6%	2%	2%
	Acute Care Hospitals	51%	20%	23%	0%	2%	4%
	Assisted/Supportive Living	56%	12%	20%	4%	0%	8%
	Personal Care Homes	77%	11%	4%	0%	8%	0%
	Other e.g. Family Care Homes, Approved Homes	45%	0%	22%	0%	33%	0%
	AADAC	75%	0%	25%	0%	0%	0%
SENIORS AND COMMUNITY SUPPORTS	**Persons with Developmental Disabilities settings**	51%	37%	6%	6%	0%	0%
	Seniors' Lodges	64%	5%	23%	5%	3%	0%
	Homeless Shelters	0%	0%	33.3%	0%	33.3%	33.3%
CHILDREN'S SERVICES	**Women's Shelters**	100%	0%	0%	0%	0%	0%

Outcomes of Abuse Complaints

Overall, for all complaints received, 63 per cent were dismissed because the complaint was unfounded or the evidence was insufficient. Thirty-seven per cent of complaints were not dismissed. The *Protection for Persons in Care Act* also enables complaints to be dismissed because the complaint was made maliciously or without reasonable and probable grounds for the belief; however, in 2004/05 no complaints were dismissed for these reasons.

Sixty-four per cent of the complaints involving agencies under Health and Wellness were dismissed and 36 per cent were not dismissed. Sixty per cent of the complaints involving agencies under Seniors and Community Supports were dismissed and 40 per cent were not dismissed.

Table 4 provides a further breakdown of the complaints dismissed and not dismissed by type of facility.

Offences

There were no prosecutions for offences under *the Protection for Persons in Care Act*; however, two files were forwarded to the Crown Prosecutor for review with respect to Section 12 of the *Protection for Persons in Care Act* (making a complaint knowing it to be false).

A third file was investigated by a contracted investigator for possible malicious reporting.

Table 4

Outcomes of Abuse Complaints by Facility Type

		Dismissed	Not Dismissed
HEALTH AND WELLNESS	Nursing Homes and Auxiliary Hospitals	65%	35%
	Acute Care Hospitals	72%	28%
	Assisted/Supportive Living	53%	47%
	Personal Care Homes	58%	42%
	Other e.g. Family Care Homes, Approved Homes	14%	86%
	AADAC	50%	50%
SENIORS AND COMMUNITY SUPPORTS	Persons with Developmental Disabilities settings	63%	37%
	Seniors' Lodges	54%	46%
	Homeless Shelters	50%	50%
CHILDREN'S SERVICES	Women's Shelters	100%	0%

Types of Persons Named or Identified as Alleged Abusers

Of the 554 reports received, 408 (73%) involved service providers as alleged abusers, 99 (18%) were clients/residents, 32 (6%) were family members and 15 (3%) were "other" types of alleged abusers (including volunteers, visitors and other third-parties).

Compared to the previous year, there were a greater percentage of service providers named as alleged abusers in 2004/05 and a smaller percentage of residents/clients named as alleged abusers.

Table 5

Types of Alleged Abusers

Type of Alleged Abuser	2004/05		2003/04	
	Actual	Percentage	Actual	Percentage
Service Provider	408	73%	423	62%
Client/Resident	99	18%	161	24%
Family	32	6%	60	9%
Other	15	3%	32	5%
	554	**100%**	**676**	**100%**

Types of Alleged Abusers by Facility/Authority Type

Eighty per cent of reports involving facilities under Regional Health Authorities named service providers as alleged abusers. Persons with Developmental Disabilities settings had a greater number of clients/residents (52%) named as alleged abusers than service providers (47%). Compared to the other facility types, seniors' lodges, unique homes and homeless shelters had service providers as the majority (72%) of alleged abusers, and the greatest percentage of family members (18%) as alleged abusers.

Table 6

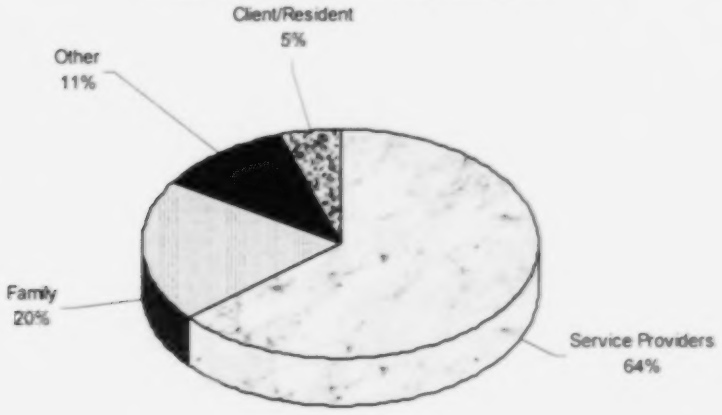
Types of Alleged Abusers by Facility Type

	Service Provider	Client/Resident	Family	Other
Regional Health Authority Facilities & AADAC	80%	11%	5%	4%
Persons with Developmental Disabilities settings	47%	52%	0	1%
Seniors' Lodges and Homeless Shelters	72%	10%	18%	0
Women's Shelters	100%	0	0	0

Types of Complainants

A significant majority (64%) of all complainants were service providers such as agency employees. Of the service providers, 49 per cent were management and 51 per cent were non-management. Family members represented 20 per cent of all complainants while only five per cent were clients/residents. The remaining 11 per cent of complainants were people such as volunteers, visitors, and other third-parties.

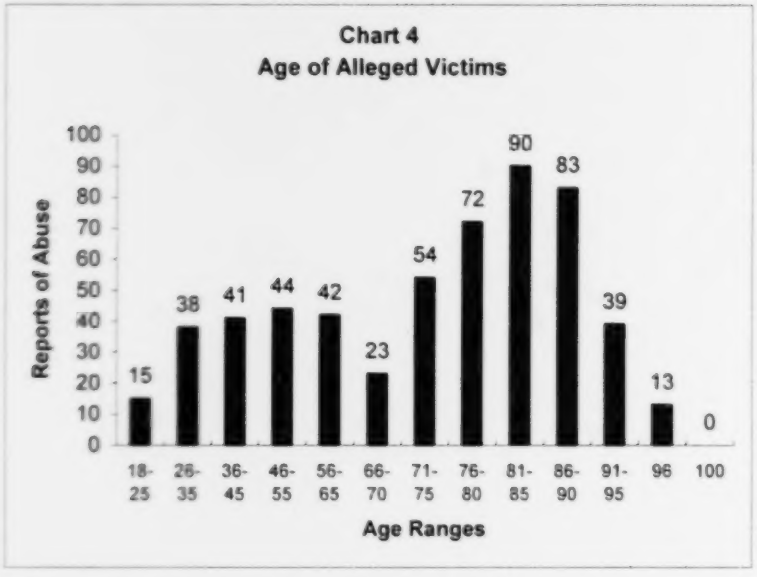
Chart 3 Types of Complainants



Characteristics of Alleged Victims: Age and Gender

There were 374 (68%) alleged victims over age 65 and 180 (32%) alleged victims age 65 and younger. Of the alleged victims over age 65, the majority (65%) were between the ages of 76 and 90 years. The most frequent complaints involved alleged victims between the ages of 81 and 85 years. The fewest complaints related to alleged victims in the youngest category (age 18 to 25) and the eldest category (age 96 to 100).

During a three-month period (January 1 to March 31, 2005), data was collected with respect to the gender of alleged victims. Overall, there was a higher percentage of females (59%) who were alleged victims compared to males (41%). Of the females, 31 per cent were between the ages of 18 and 65 years and 69 per cent were age 66 and older. Of the males, 43 per cent were between the ages of 18 and 65 years and 57 per cent were age 66 and older.



Note: In Chart 4, ages are in increments of 10 years from 18 to 65 years and in increments of 5 years after age 65.

Investigations

In response to the 554 reports received by Protection for Persons in Care, 457 investigations were completed; however, four investigations, conducted by professional associations, remain open. The total number of investigations is less than the total number of reports because one investigation may involve multiple reports.

Protection for Persons in Care contracts with approximately 20 investigators across the province. The investigators have varying backgrounds ranging from differing health professions to law enforcement.

Of the 457 investigations, Protection for Persons in Care conducted 434 investigations by appointing contracted investigators. Fifteen of the 457 investigations were done by a professional association, two by the Office of the Mental Health Patient Advocate, and five by a police service. Of the 15 investigations done by a professional association, nine were done by the College of Licensed Practical Nurses of Alberta, five by the College of Physicians and Surgeons of Alberta, and two by the Alberta College of Social Workers.

While five reports were referred to the police for investigation, there were 11 other reports that had police involvement such as consultation or joint investigation.

Investigation Duration

Starting January 2005, data was collected on the time taken to complete each investigation; there were 95 files closed in January, February and March 2005. Of the 95 files closed during this time, external investigators contracted by Protection for Persons in Care conducted 97 per cent of the investigations. The average time taken to conclude an investigation was 37 days.

During the same three-month period, a Professional Association investigated three of the 95 closed files. The average investigation duration was 194 days.

Ministry Review Time

After an investigation is complete, and when Protection for Persons in Care receives the investigator's final report, staff thoroughly review each report before the Ministry makes a decision. This includes reviewing the investigator's report, and preparing a report of decision and related correspondence. Starting in January 2005, data was collected for the closed files. The average time taken for ministry review during the three-month period (January, February and March 2005) shows that the average review time was 37days.

Information, Awareness and Education

The first point of contact for most members of the public with Protection for Persons in Care is the 1-888-357-9339 reporting and information line. Records indicate that 1649 telephone calls were logged in 2004/05. A significant amount of time is devoted to responding to incoming telephone calls from the public, employees, service providers, and residents of various facilities. In addition to receiving complaints of abuse, Protection for Persons in Care also provides referrals to other jurisdictions, law enforcement agencies, other departments, and community service organizations.

Twenty-one educational information sessions for various student groups across the province were attended by 630 participants.

To increase awareness, Protection for Persons distributed 28,500 brochures and 600 posters to the public, facilities, and service providers.

Policy Developments

Protection for Persons in Care released one new Bulletin on its web site: www.seniors.gov.ab.ca. Bulletin 8, developed September 2004, describes the complaint process. In general, bulletins provide information about procedures and practices for the effective and consistent administration of the *Protection for Persons in Care Act.*

This year, Protection for Persons in Care developed a comprehensive Operational Procedures Manual to guide the work of the branch. The Protection for Persons in Care Operational Procedures Manual provides direction and explains required procedures to staff who are responsible for administering the *Protection for Persons in Care Act.*

In response to recommendations made by the Ombudsman, Protection for Persons in Care began initial planning to change its complaints and investigation process to better reflect principles of administrative fairness. These changes are to be implemented in 2005/06.

Branch Reorganization

In 2004/05, the Protection for Persons in Care branch altered its organizational structure, creating two functional units. One unit manages complaints and investigations and a second unit addresses policy and planning. Within the operational unit, a case management model was implemented with Abuse Prevention Consultants having responsibility for managing all aspects of complaints, from the time the initial complaint is taken, until the file is closed and follow-up is complete.

Complainant Satisfaction Survey

Beginning January 2005, Protection for Persons in Care surveyed complainants who reported abuse to determine their satisfaction with specific aspects of the abuse reporting and investigation process. As of March 31, 2005, 30 per cent of complainants surveyed had responded.

Seventy-two per cent of all respondents were service providers, 24 per cent were a resident, client or family member, and four per cent were "other."

The completed surveys indicated that most complainants became aware of the Protection for Persons in Care reporting line through brochures, posters or educational sessions.

When complainants first contacted the Protection for Persons in Care office, 88 per cent said they were satisfied with the way their call was handled, eight per cent were not satisfied and four per cent did not respond.

Respondents were generally very satisfied with the investigator and the investigation process; 92 per cent of respondents said the investigator explained how the investigation would proceed, and 100 per cent said that the investigator treated them courteously. Ninety-six per cent of respondents indicated the investigator invited them to meet for a personal interview, clarified the details of the complaint, and answered the complainant's questions.

Sixty-eight per cent of respondents were dissatisfied with the time taken to complete the entire process, from the time the complainant first made the complaint to the conclusion. Thirty-two per cent were satisfied.

Seventy-two per cent of respondents were satisfied with the extent of information provided in the "Summary of Key Information Gathered" in the *Report of Decision*. Twenty per cent were not satisfied, and eight per cent did not respond to the question.

Seventy-six per cent of respondents were satisfied with the focus of the "Recommendations" in the *Report of Decision*. Twenty per cent were not satisfied, and four per cent did not respond.

Forty per cent indicated that there was something that could have been done to improve the process, 44 per cent indicated that there was nothing more that could have been done to improve the process, and 16 per cent did not respond.

Recommendations

Recommendations were made in 98 per cent of the reports investigated by Protection for Persons in Care. The majority of recommendations focused on:

- making improvements to some aspect of care or services provided to the person;
- communication with and amongst residents, family members, and staff;
- education of staff; and
- enhancement of agency policy or procedures.

Twenty-seven reports included recommendations relating to disciplinary action, and six reports recommended the referral of a health professional to their respective professional association for a review of their practice.

Follow-Up to the Recommendations

As part of follow-up, Protection for Persons in Care requests that the agency provide a written reply within 90 days in response to the recommendations made. There was a 99 per cent rate of reply from the agencies in which a request for a response was made. For those agencies that do not respond, further follow-up occurs by telephone.

Many agencies also take action prior to receiving the recommendations and/or the agencies implement changes over and above the recommendations made.

Concluding Statement

Protection for Persons in Care has a mandate that includes responding to complaints, conducting investigations, and making recommendations to enhance safeguards for Albertans. Protection for Persons in Care acknowledges the contributions of all individuals and organizations in trying to achieve this important objective.

APPENDIX 1

Samples of Complaints, Recommendations and Follow-up

The following are samples of complaints made to Protection for Persons in Care and the recommendations made or action taken by agencies.

Bathing Incidents

In 2004/05, there were several complaints made to Protection for Persons in Care relating to residents who sustained burns from bathing.

Recommendations Related to Bathing Incidents

The following is a sample of some of the recommendations made to agencies following investigation of bathing incidents.

- That the agency review and enhance its policy on bathing procedures involving the century tub system by adding the requirements that:
  a) residents never be placed into the tub while the tub is filling with water,
  b) residents are only to be placed into the tub after the tub has been fully and completely filled with water, and only after the water has been physically checked by staff,
  c) staff immerse their bare hand up to the elbow, to check for a safe water temperature,
  d) staff visually check the temperature gauge to ensure that the water temperature is set at a safe temperature level.
- That the agency ensure residents whose circumstances and needs warrant constant supervision, never be left alone in a bathtub.
- That the agency clearly communicate all such policy revisions to all staff, stressing the need to focus on prevention of scalds and burns.
- That the agency explore whether the century tub valve mechanism/temperature gauge warrants preventive maintenance checks at regular intervals by a technician familiar with the century tub system.
- That the agency review its practices for assessing residents who have been involved in incidents in which injuries have been sustained and/or the potential for injury may become apparent, and identify processes for staff to follow, including, but not limited to, the provision of immediate first aid treatment, observation, consultation with health professionals, and arrangement for medical treatment.
- That the agency ensure that all staff receive increased education and training on burn prevention, burn recognition and treatment of burns and scalds, either in addition to existing First Aid training or in conjunction with refresher courses.
- That the agency review its practices concerning the supervision and coaching of staff who work alone on the night shift and explore options for increasing the amount of contact, supervision and coaching that night staff receive from their supervisor(s).

- That the agency determine if the circumstances warrant closer supervision of the staff person or reassignment to a shift other than nights, to enable the staff person to work closely with another staff member.

- That the agency review its practices concerning the supervision and briefing of relief staff who work alone, to ensure that such relief staff are fully apprised of their duties and expectations for meeting client care needs, prior to working shifts.

- That the agency review the (policy) requirements for completing shift reports and incident reports with the staff person, and issue a reminder for other direct care staff.

- That the agency review communication practices amongst staff during shift change and following critical incidents, to ensure that oncoming staff and others are fully apprised of situations of real concern and of potential concern.

Infection Control Practices

In regard to infection control practices, investigation of several complaints determined that some agencies providing services did not have any policies or procedures, based on best practices, that address health and safety with respect to food handling, food preparation, water temperature, cleaning of equipment, cleaning of residential surfaces or laundry.

Recommendations Related to Infection Control Practices

After investigation of these complaints, the following recommendations were made:

- That the agencies develop and implement: infection control standards based on best practices, policies and monitoring processes relating to food handling and preparation, and environmental health and safety procedures to further its efforts in maintaining a reasonable level of health and safety for the individuals it serves;

- That the agencies ensure that all staff receive relevant training to increase their knowledge and application of infection control standards in accordance with the standards developed by the agency and incorporated into policy;

- That the agencies integrate into the job descriptions of all staff, the duty to adhere to agency infection control standards in an effort to promote the health and safety of residents.

Inappropriate Staff Interaction With Residents

Several complaints were received in which staff interacted inappropriately with residents or threatened or intimidated residents.

The agencies conducted investigations into the incidents and determined that some residents felt threatened by the staff person's presentation, both verbally and non-verbally.

Agencies took disciplinary action and/or identified "expectations for improvement." Specific expectations for staff included:

a) Adhere to the agency's code of ethics and treat people with dignity and respect;
b) Use positive, affirming and non-threatening verbal communication with residents;
c) Use a supportive approach and remain positive, tactful and respectful with words and tone of voice;
d) Not to place any resident in a position where he/she feels scared or threatened.
e) Talking to residents in a kind, gentle tone of voice.
f) Participate in formal performance reviews at regular intervals to review performance and interactions with residents.

Resident Sustained A Swollen Leg, Bedsores And Other Health Concerns While At A Respite Facility For 35 Days

The facility developed an action plan as follows:

a) Disciplinary action and an education plan for the staff person involved.
b) Additional training on physical assessment for the facility's staff.
c) Education sessions for the staff on the "duty to report."
d) Review of respite care process with professional staff on the respite unit, with an emphasis on nursing assessment and care planning.
e) Requirement that professional staff conduct and document an assessment on the person admitted for respite upon admission and the day prior to discharge.
f) Review of the documentation of all respite admissions by a program leader for six months to ensure documentation by staff is complete.
g) Review of skin care and turning protocols with the staff and re-implementation of turning flow sheet logs.
h) More thorough review of respite admission care needs and discussions with families regarding facility expectations in supplementing care if needed.